PRINTED: 7/19/2023 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER 395998			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 10/20/2022		
NAME OF PROVIDER OR SUPPLIER: MISERICORDIA NURSING & REHABILITATION CENTER STATE LICENSE NUMBER: 133302			STREET ADDRESS, CITY, STATE, ZIP CODE: 998 SOUTH RUSSELL STREET YORK, PA 17402				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC' MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0000	Based on a Medicare/I State Licensure, and Con October 20, 2022, a Rehabilitation Center, were no deficiencies in requirements of 42 CF Requirements for Long 28 PA Code, Common Term Care Licensure I	civil Rights survey count Misericordia Nursit was determined the dentified under the FR Part 483 Subpart of Term Care Facilities wealth of Pennsylva	ompleted sing and nat there B, es and the	F 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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Certified End Page

MISERICORDIA NURSING & REHABILITATION CENTER

STATE LICENSE NUMBER: 133302 SURVEY EXIT DATE: 10/20/2022

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY